U.S. Department of Labor

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Issue Date: 08 September 2006

Case No.: 2005BLA-05233

In the Matter of

D. P.
Claimant

v.

H & P COAL COMPANY, INC.
Employer

and

AMERICAN RESOURCES INSURANCE CO.
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

Appearances: EDMOND COLLETT, Esq. For Claimant
E. BRETT STONECIPHER, Esq. For Employer

Before: ADELE HIGGINS ODEGARD
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. §§ 901-945 ("the Act") and the regulations issued thereunder, which are found in Title 20 of the Code of Federal Regulations. Regulations referred to herein are contained in that Title.

Benefits under the Act are awarded to coal miners who are totally disabled within the meaning of the Act due to pneumoconiosis, or to the survivors of coal miners whose death was due to pneumoconiosis. Pneumoconiosis, commonly known as black lung, is a disease of the lungs resulting from coal dust inhalation.

On November 18, 2004, this case was referred to the Office of Administrative Law Judges for a formal hearing. Subsequently, on April 17, 2006, the case was assigned to me. The hearing was held before me in London, Kentucky, on April 26, 2006, at which time the parties had full opportunity to present evidence and argument. The decision that follows is based upon an analysis of the record, the arguments of the parties, and the applicable law.

I. ISSUES

The following issues are presented for adjudication.[1]

(1) Whether the Claimant has pneumoconiosis;
(2) whether his pneumoconiosis, if any, arose from coal mine employment;
(3) whether the Claimant is totally disabled; and
(4) whether the Claimant's total disability, if any, is due to pneumoconiosis.

II. PROCEDURAL BACKGROUND

The Claimant filed this claim for benefits on December 1, 2003 (DX 2).[2] On September 3, 2004, the District Director issued a proposed Decision and Order awarding benefits to the Claimant from the date of the filing. The Employer rejected the Director's determination and, on September 13, 2004, requested a formal hearing. The Employer declined to pay benefits prior to formal adjudication of the Claim; consequently, as authorized in § 725.522, the Black Lung Disability Trust Fund has made monthly payments to the Claimant. These payments are subject to reimbursement if the Claimant's entitlement to benefits is upheld. See § 725.602.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Factual Background

The Claimant was born in 1948. He is unmarried and has no minor children (DX 2). His Social Security records reflect that he was employed in various non-mining occupations until 1970. In that year he began work for the H & P Coal Company, and worked for that employer until 1987. The record also indicates that he was employed by at least one other coal mine operator in the mid-1970s, and that he worked for other coal mine operators for short periods of time in 1988 and 1989.[3] According to his Social Security records the Claimant had no employment between 1990 and 1996, and then he worked for a motorcycle dealer between 1997 and 2002 (DX 8, 9).[4]

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[1] The parties stipulated that the Claimant has 17 years of coal mine employment. I find that the record supports this stipulation.

[2] The following abbreviations are used in this Opinion: "DX" refers to Director's Exhibits; "CX" refers to Claimant's Exhibits; "EX" refers to Employer's Exhibit's; "T" refers to the transcript of the April 26, 2006 hearing.

[3] The Employer has withdrawn his controversion of the issue of responsible operator (T at 8).

[4] The Social Security Administration's report reflects that only the years 1978-2002 were requested when the District Director processed the Claimant's claim (DX 1).

B. Claimant's Testimony

The Claimant testified under oath at the hearing, and said that he has never smoked in his life. He stated that he worked as a drill operator at an above-ground coal site for 17 years (T at 12). The drill had an enclosed cab but was not air-conditioned, so the doors would be left open (T. at 13). He was exposed on a daily basis to a combination of rock dust and coal dust, because he was drilling through coal seams (T. at 13-14).

The Claimant testified that he left coal mining in 1987 due to illness but went back to work, and last worked in 2003 in a motorcycle shop (T. at 15). He said that he has trouble breathing, which has gotten worse since he left his last employment in 2003 (T. at 16). He is currently receiving treatment for his respiratory problems, which include inhalers and nebulizer treatments (T. at 16-17). He testified that he is often short of breath, has difficulty sleeping, and cannot walk short distances without stopping to rest (T. at 17-19).

C. Relevant Medical Evidence

The Claimant presented a pulmonary function study which was part of the pulmonary evaluation conducted in conjunction with the Claimant's present claim (DX 12). See § 725.406. Additionally, the Claimant presented medical treatment records, which included records of medical tests (DX 14). § 725.414(a)(4). The Employer presented medical reports (including medical test results) from Dr. Bruce C. Broudy and Dr. Byron Westerfield (DX 29 and 35, respectively), as well as hospitalization and treatment records pertaining to the Claimant (EX 6 and 7). The Employer also submitted one X-ray interpretation, by Dr. Harold B. Spitz, as rebuttal evidence (DX 29). See § 725.414(a)(3)(ii). These items will be discussed in greater detail below.

D. Entitlement

Because this claim was filed after January 19, 2001, the Claimant's entitlement to benefits is evaluated under the revised regulations set forth at 20 C.F.R. Part 718. The Act provides for benefits for miners who are totally disabled due to pneumoconiosis. 20 C.F.R. § 718.204(a). In order to establish an entitlement to benefits under Part 718, the Claimant bears the burden to establish the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis; (2) the pneumoconiosis arose out of coal mine employment; (3) the miner is totally disabled; and (4) the miner's total disability is caused by pneumoconiosis. Director, OWCP v. Greenwich Collieries, 512 U.S. 267 (1994).

1. Elements of Entitlement:

Pneumoconiosis Defined:

Section 718.201(a) defines pneumoconiosis as "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical or "clinical" pneumoconiosis, and statutory,

or "legal" pneumoconiosis, which themselves are defined in that subparagraph at (1) and (2). "Clinical" pneumoconiosis consists of diseases recognized by the medical community as pneumoconioses, characterized by permanent deposition of substantial amounts of particulates in the lungs, and the fibrotic reaction of the lung tissue, caused by dust exposure in coal mine employment. "Legal" pneumoconiosis includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This encompasses, but is not limited to, any chronic restrictive or obstructive pulmonary disease. A disease "arising out of coal mine employment" is defined as including "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment." § 718.201(b)

a. Whether the Claimant has Pneumoconiosis

There are four means of establishing the existence of pneumoconiosis, set forth at §§ 718.202(a)(1) through (a)(4):

(1) X-ray evidence: § 718.202(a)(1).
(2) Biopsy or autopsy evidence: § 718.202(a)(2).
(3) Regulatory presumptions: § 718.202(a)(3).[5]
(4) Physician opinion based upon objective medical evidence: § 718.202(a)(4).

X-ray Evidence

Section 718.202(a)(1) states that a chest X-ray conducted and classified in accordance with § 718.102[6] may form the basis for a finding of the existence of pneumoconiosis. The current record contains the following chest X-ray evidence:

[5] These are as follows: (a) An irrebutable presumption of total disability due to pneumoconiosis if there is evidence of complicated pneumoconiosis (§ 718.304); (b) where the claim was filed before January 1, 1982, a rebuttable presumption of total disability due to pneumoconiosis if the miner has proven fifteen (15) years of coal mine employment and there is other evidence demonstrating the existence of totally disabling respiratory or pulmonary impairment (§ 718.305); or (c) a rebuttable presumption of entitlement applicable to cases where the miner died on or before March 1, 1978 and was employed in one or more coal mines prior to June 30, 1971 (§ 718.306).

[6] ILO Classifications 1, 2, 3 A, B, or C shall establish the existence of pneumoconiosis; Category 0, including subcategories 0/0 and 0/1, do not establish pneumoconiosis. Category 1/0 is ILO Classification 1.

Date of X-Ray	Date Read	Ex.No.	Physician	Radiological Credentials[7]	Interpretation
01/09/2004	01/09/2004	DX 12	Baker	B Reader	ILO: 1/0
01/09/2004	06/04/2004	DX 29	Spitz	BCR, B reader[8]	Neg. for pneumoconiosis[9]
06/14/2004	06/14/2004	DX 29	Broudy	B Reader	ILO: 0/1
07/21/2004	07/21/2004	DX 35	Westerfield	B Reader	ILO: 0/1

It is well established that the interpretation of an X-ray by a B-reader may be given additional weight by the fact-finder. Aimone v. Morrison Knudson Co., 8 B.L.R. 1-32, 34 (1985); Martin v. Director, OWCP, 6 B.L.R. 1-535, 537 (1983). The Benefits Review Board has also held that the interpretation of an X-ray by a physician who is a Board-certified radiologist as well as a B-reader may be given more weight than that of a physician who is only a B-reader. Scheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128, 131 (1984). Additionally, a finder of fact is not required to accord greater weight to the most recent X-ray evidence of record. Rather, the length of time between the X-ray studies and the qualifications of the interpreting physicians are factors to consider. McMath v. Director, OWCP, 12 B.L.R. 1-6 (1988); Pruitt v. Director, OWCP, 7 B.L.R. 1-544 (1984); Gleza v. Ohio Mining Co., 2 B.L.R. 1-436 (1979).

In this case there are three different X-ray studies, all taken within a six-month time period. Dr. Baker, who is a B reader but not a Board-certified radiologist, is the only physician to read an X-ray as positive for pneumoconiosis. Dr. Spitz, who is a Board-certified radiologist and a B reader, read the same X-ray as negative for pneumoconiosis, but noted other abnormalities. Dr. Broudy and Dr. Westerfield, who are both B readers, interpreted other X-rays as ILO level 0/1, which is considered negative for pneumoconiosis.

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[7] A B-reader is a physician who has demonstrated proficiency in assessing and classifying X-ray evidence of pneumoconiosis by successful completion of an examination conducted by the National Institute for Occupational Safety and Health (NIOSH). NIOSH is a part of the Centers for Disease Control and Prevention, in the U.S. Department of Health and Human Services. See 42 C.F.R. § 37.51 for a general description of the B reader program. A physician who is a Board-certified radiologist ("BCR") has received certification in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Board of Radiology. See generally: http://www.answers.com/topic/radiology#after_ad1.

[8] Dr. Spitz's credentials were not included in the record. I verified his credentials through use of the American Board of Medical Specialties website, and the website of the National Institute for Occupational Safety and Health (NIOSH). See generally www.abms.org. and http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html. Per order of January 11, 2006, the parties were informed that the administrative law judge might use the internet to obtain or verify physician credentials, and provided the opportunity to object. No party objected.

[9] Dr. Spitz's report noted an elongated aorta and elevated left diaphragm, but no evidence of pneumoconiosis.

Based on the fact that there is only one X-ray, from January 2004, that has been read as positive for pneumoconiosis, and that a dually-qualified Board-certified radiologist/B reader has interpreted that same X-ray as negative for the disease, I conclude that the Claimant is unable to establish, by a preponderance of evidence, the existence of pneumoconiosis through X-ray evidence.

Biopsy or Autopsy Evidence

A determination that pneumoconiosis is present may be based on a biopsy or autopsy. § 718.202(a)(2). That method is not available here, as the current record contains no such evidence.

Regulatory Presumptions

A determination of the existence of pneumoconiosis may also be made using the presumptions described in §§ 718.304, 718.305, and 718.306. Section 718.304 requires X-ray, biopsy, or equivalent evidence of complicated pneumoconiosis, which is not present in this case. Section 718.305 is not applicable because this claim was filed after January 1, 1982. §718.305(e). Section 718.306 applies only in cases of deceased miners who died before March 1, 1978. Since none of these presumptions apply in this case, the existence of pneumoconiosis has not been established under § 718.202(a)(3).

Physician Opinion

The fourth way to establish the existence of pneumoconiosis under § 718.202 is set forth in subparagraph (a)(4): A determination of the existence of pneumoconiosis may also be made if a physician exercising sound medical judgment, notwithstanding a negative X-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Taylor v. Director, OWCP, 9 B.L.R. 1-22 (1986). Any such finding shall be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

A medical opinion is well documented if it provides the clinical findings, observations, facts and other data the physician relied on to make a diagnosis. Fields v. Island Creek Coal Co., 10 B.L.R. 1-19 (1987). An opinion that is based on a physical examination, symptoms, and a patient's work and social histories may be found to be adequately documented. Hoffman v. B. & G Construction Co., 8 B.L.R. 1-65 (1985). A medical opinion is reasoned if the underlying documentation and data are adequate to support the findings of the physician. Fields, supra. A medical opinion that is unreasoned or undocumented may be given little or no weight. Clark v. Karst-Robbins Coal Co., 12 B.L.R. 1-149 (1989).

As stated above, the definition in § 718.204(a) of pneumoconiosis includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis, which are defined, respectively, in § 718.202(a)(1) and (2). Under this definition, legal pneumoconiosis includes

chronic bronchitis, chronic obstructive pulmonary disease, and other pulmonary diseases, when they are causally related to coal mine employment.

Dr. Glen R. Baker (DX 12; DX 38; CX 1).

In January 2004, Dr. Baker performed the pulmonary evaluation provided for the Claimant by the Department of Labor in conjunction with his filing of this Claim (DX 12). See § 725.406. He is Board-certified in internal medicine and pulmonary medicine, and is a B reader (CX 1). In his written report Dr. Baker concluded that the Claimant had coal workers' pneumoconiosis category 1/0, based on abnormal X-ray and coal dust exposure. He also stated that the Claimant had "COPD with moderate obstructive defect" based on the pulmonary function study; severe hypoxemia, based on the oxygen value in the arterial blood gas test; and chronic bronchitis, based on history, as well as "ischemic heart disease" based on history. He characterized the Claimant's degree of disability as moderate. His report listed "coal dust exposure" as the sole cause of all the Claimant's respiratory conditions.

During the administrative processing of the Claimant's claim, the Director sought Dr. Baker's response to the X-ray report submitted by Dr. Spitz, in which Dr. Spitz interpreted as negative the same X-ray Dr. Baker had read as evidencing pneumoconiosis. Dr. Baker responded that he respected Dr. Spitz's professional judgment, but that he read the X-ray differently, and Dr. Baker reiterated that he interpreted the Claimant's X-ray as evidencing pneumoconiosis in ILO category 1/0 (DX 38).

Various medical treatment and hospitalization records (DX 14; EX 6; EX 7).

The Claimant presented medical treatment records from Dr. Abdi Vaezy, covering the time period from June to December 2003. Dr. Vaezy is the Claimant's treating physician (T. at 16-17). These treatment records included records of pulmonary function and arterial blood gas tests, as well as a bronchoscope examination conducted in September 2003 (DX 14). No separate medical report from Dr. Vaezy was submitted. Dr. Vaezy's bronchoscope report stated that the Claimant has "acute on chronic bronchitis" and that he "seems to have stage 1 coal workers' pneumoconiosis and a severe degree of chronic bronchitis" (DX 14 at 8).

The Employer presented medical treatment and hospitalization records from the Baptist Regional Medical Center, dated June and September 2003 (EX 6) and from Knox County Hospital, dated May 2003 (EX 7). In May 2003, the Claimant was admitted to the hospital in congestive heart failure with acute pulmonary edema. In June 2003, he was admitted for hypoxia. In September 2003, he was admitted for hypoxia with pulmonary edema. These treatment and hospitalization records consisted of progress notes, plus narrative reports of X-rays, bronchoscope,[10] cardiac catheterization and cardiac echogram. Dr. Westerfield's supplemental reports, mentioned below, discussed these treatment and hospitalization records.

[10] This is the same bronchoscope examination that appears in Dr. Vaezy's treatment records.

Dr. Bruce C. Broudy (DX 25; DX 37).

Dr. Broudy examined the Claimant at the request of the Employer in June 2004 and submitted a medical report (DX 25). The medical report contained the results of a chest X-ray, pulmonary function study, and arterial blood gas test Dr. Broudy administered. Dr. Broudy, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, also testified by deposition (DX 37).

In his written report, Dr. Broudy concluded that the Claimant did not have pneumoconiosis, and diagnosed "chronic bronchitis by history." He noted that the Claimant had "very slight increase in interstitial nodularity," which he characterized as ILO level 0/1. Dr. Broudy noted that "on spirometry the patient's effort was not good. There is evidence of restriction which may in part be related to effort. There was slight improvement after bronchodilation" (DX 29 at 7). However, the technician's comments on the pulmonary function test report itself reflect "nice man, cooperative, fairly good effort and technique" (DX 29 at 10). Dr. Broudy also noted: "The lung volumes suggest airways obstruction....The diffusing capacity was mildly diminished….Airways resistance is increased," and reported that the blood gas test showed moderate hypoxemia. Dr. Broudy concluded that "it is likely that [the Claimant] does not retain the respiratory capacity to perform the work of an underground coal miner or to do similarly arduous manual labor" (DX 29 at 7-8).

Dr. Byron T. Westerfield (DX 35; EX 1, 2, and 3).

Dr. Westerfield, who is Board-certified in internal medicine and pulmonary medicine and is a B reader, examined the Claimant at the request of the Employer in July 2004, and submitted a medical report (DX 35). This report contained the results of a chest X-ray, pulmonary function study, and arterial blood gas test Dr. Westerfield administered. Dr. Westerfield later wrote two supplemental reports, dated January and March 2005, respectively (EX 2 and 3), which were admitted into evidence without objection from the Claimant's counsel (T. at 7).[11] Dr. Westerfield also testified by deposition (EX 1).

In his initial medical report, Dr. Westerfield opined that the Claimant does not have coal workers' pneumoconiosis, based on the Claimant's chest X-rays, and also the fact that "his respiratory symptoms began years after he left coal mining." Dr. Westerfield concluded that the Claimant had chronic obstructive pulmonary disease, which appeared to be primarily chronic bronchitis, and that the chronic bronchitis was due to "repeated acute infections." Dr. Westerfield also stated that the Claimant "is totally disabled from respiratory disease" and would be unable to perform his previous position in coal mining (DX 35 at 2-3).

In his first supplemental report, Dr. Westerfield commented on the Claimant's May 2003 hospitalization for congestive heart failure. Dr. Westerfield noted that congestive heart failure can be resolved with adequate treatment, but there can be residual dyspnea on exertion. Dr.

[11] I considered Dr. Westerfield's supplemental reports as a continuation of his initial medical report. See § 725.414(a)(1).

Westerfield concluded that at least some of the Claimant's breathing difficulties were due to the effect of his congestive heart failure (EX 2).

In his second supplemental report, Dr. Westerfield reviewed the record of the Claimant's June and September 2003 hospitalizations. Based on his review, Dr. Westerfield concluded that the Claimant had congestive heart failure, causing respiratory failure. Dr. Westerfield determined that there is "no link between his present respiratory problems and inhalation of coal dust," and cited the fact that the Claimant's symptoms began about 14 years after he left coal mine employment (EX 3 at 2).

At deposition Dr. Westerfield testified that the Claimant's chronic bronchitis was most likely the result of acute lung infections, which may have been triggered by exposure to noxious fumes or dust in his post-coal mine employment as a mechanic, but may have been just due to normal exposures of everyday life. He testified that the Claimant had no respiratory symptoms when he left the mines in 1989, and continued to work in very active jobs for a number of years thereafter. Dr. Westerfield found no link between the Claimant's inhalation of coal dust and the respiratory conditions the Claimant developed years later (EX 1 at 12-16).

Discussion

I find that the weight of physician opinion, summarized above, does not establish that the Claimant has coal workers' pneumoconiosis (clinical pneumoconiosis). The only physician to diagnose the Claimant with that condition is Dr. Baker, who found evidence of abnormal X-ray. Dr. Baker, however, is not a Board-certified radiologist, as Dr. Spitz is. Dr. Spitz read as negative the same X-ray that Dr. Baker read as positive for pneumoconiosis. Dr. Broudy and Dr. Westerfield, who are B readers, did not read the Claimant's other X-rays as positive for pneumoconiosis. Dr. Baker did not articulate how the results of his physical examination of the Claimant, or the Claimant's medical test results, were consistent with the respiratory effects of coal workers' pneumoconiosis. Consequently, there is little objective evidence of the disease.

Likewise, I find that the medical reports and treatment records do not establish the existence of clinical coal workers' pneumoconiosis in this Claimant. Although Dr. Vaezy's bronchoscope report includes the statement that the Claimant "seems to have" coal workers' pneumoconiosis, the report does not indicate how Dr. Vaezy came to that conclusion. Consequently, I give Dr. Vaezy's conclusion little weight.

Similarly, I give Dr. Broudy's and Dr. Westerfield's little weight. Dr. Broudy provides only a conclusory statement that he does not believe the Claimant has coal workers' pneumoconiosis. Dr. Westerfield bases his conclusion that the Claimant does not have the disease primarily on the fact that the Claimant was not been in the mines since 1989. Because coal workers' pneumoconiosis is recognized as a latent and progressive disease, the fact that the Claimant had not been in coal mine employment for a number of years is irrelevant to a diagnosis. Peabody Coal Co. v. Odom, 342 F.3d 486 (6th Cir. 2003). See § 718.201(c).

However, as the definition of pneumoconiosis under the Act includes so-called "legal" pneumoconiosis, the analysis of whether the Claimant has established that he has

pneumoconiosis does not end with a discussion of coal workers' (clinical) pneumoconiosis. Under the facts of this case, chronic pulmonary obstructive disease and chronic bronchitis, if they arise from coal mine employment, fall within the definition of pneumoconiosis. See § 718.201(a)(2). In this context, the phrase "arising from coal mine employment" requires that these conditions be significantly related to, or aggravated by, dust exposure in coal mine employment. § 718.201(b). See also Ligon v. Martin Preparation Co., 400 F.3d 302 (6th Cir. 2005).

As the Claimant's hospitalization and treatment records make clear, the Claimant has a history of both chronic bronchitis and acute episodes of respiratory crisis. Dr. Baker's report, dated January 2004, recorded that the Claimant had chronic bronchitis for more than two years and that he had wheezing, dyspnea, cough, orthopnea, and ankle edema for this same timeframe. Dr. Baker diagnosed both chronic obstructive pulmonary disease and chronic bronchitis, and attributed these conditions to the Claimant's coal dust exposure. This report stated that the Claimant had a mild obstructive defect and severe resting arterial hypoxemia, but did not specifically articulate how coal dust exposure caused these conditions, nor does his report explain how the objective medical test results show that the Claimant's conditions were due to coal dust exposure rather than some other source. In his later comments to the Director's office, however, Dr. Baker clarifies his earlier comment by remarking that the Claimant "could have an asthmatic condition or other causes of obstructive airway disease but the only obvious cause is that of coal mine exposure" (DX 38 at 3).

Dr. Vaezy's treatment records, which begin in 2003, establish that the Claimant had both chronic bronchitis and acute bronchitis episodes, and that Dr. Vaezy considered that the Claimant may have pneumoconiosis, from the onset of Dr. Vaezy's treatment. Dr. Vaezy's records noted there was no good explanation for the Claimant's lung disease, as established by pulmonary function tests, as the Claimant was a non-smoker (DX 14 at 8-9). Dr. Vaezy did not explicitly link the Claimant's restrictive impairment or bronchitis to his coal mine employment, but did not provide any other direct explanation for the Claimant's lung condition.

Dr. Broudy's written report gave a rather complete description of the Claimant's physical condition, but provided only a conclusory opinion that the Claimant's condition was not related to coal dust inhalation. In his deposition, Dr. Broudy speculated that the Claimant's restrictive lung defect had both pulmonary and non-pulmonary causes, listing congestive heart failure as one of several possible non-pulmonary causes. Dr. Broudy's comment is coupled with a statement about the Claimant's lack of effort for the pulmonary function test, implying that the results are not reliable. This statement is inconsistent with the technician's comment, as noted above. Because Dr. Broudy's statement that the Claimant's lack of effort may account for the finding that he has a restrictive defect is inconsistent with the record, I disregarded that comment. Based on the fact that Dr. Broudy's determination is conclusory, and his explanation for the test results is not supported by the record, I find that Dr. Broudy's report is not well-reasoned, and I assign it little weight.

Dr. Westerfield's testimony that the Claimant had no respiratory symptoms when he left the mines in 1989 mines is contradicted by the history Dr. Westerfield himself took, in which the

Claimant told him he left the mines because of breathing problems (DX 35 at 4).[12] In addition, in speculating that the Claimant may have damaged his lungs through exposure to fumes as a mechanic, Dr. Westerfield overstated the number of years that the Claimant held such employment (EX 1 at 12-16).[13] The record is silent as to whether the Claimant was exposed to noxious fumes or dust in his post-coal mine employment, and in the absence of such evidence I decline to infer that he was so exposed.[14]

Based on the fact that Dr. Westerfield's conclusion is based on speculation and inaccurate information, I find his report not to be well-reasoned, and I assign it little weight. I also assign little weight to Dr. Westerfield's opinions because his second supplemental report, in which he attributes the Claimant's pulmonary impairment to congestive heart failure, contradicts his own physical examination of the Claimant, in which congestive heart failure is not mentioned.[15]

I assign some weight to Dr. Vaezy's comments in his treatment records. Dr. Vaezy is the Claimant's treating physician, and he observed the Claimant over a period of months. These records, which include objective medical tests, document the Claimant's deteriorated respiratory condition, and provide a contemporaneous picture of the Claimant's degree of impairment. I give appropriate consideration to those records. See § 718.104(d). Dr. Vaezy's notes also highlight the fact that Dr. Vaezy has not found a cause more immediate than coal dust exposure to explain the Claimant's condition.[16]

Taken together, I find Dr. Baker's initial report and his subsequent comments to constitute one report. In these reports, Dr. Baker assesses the Claimant's pulmonary condition, as evidenced by a medical history, physical examination, and objective test results. Dr. Baker, who was aware of the Claimant's many medications and the fact that the Claimant had been hospitalized three times the year before, considered a history of bronchitis, wheezing and dyspnea predating the Claimant's hospitalizations and concluded that there was no explanation,

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[12] This document is also appended as an Exhibit to Dr. Westerfield's deposition. In his deposition, the Claimant also testified that he left the mines due to breathing problems (EX 5 at 11).

[13] Dr. Westerfield's testimony presumed that the Claimant worked as a mechanic from 1989 to 2003. Dr. Westerfield's own report states that the Claimant worked as a mechanic from 1995 to 2003; the Social Security records indicate that the Claimant did not work at all for the years 1990 through 1996 (See DX 8).

[14] The Employer submitted two depositions of the Claimant (EX 4 and 5). The Claimant is questioned about his post-coal mine employment, but his possible exposure to noxious fumes or dust after he left the mines is not mentioned.

[15] The Claimant was hospitalized for congestive heart failure in 2003. Dr. Westerfield examined the Claimant in 2004. If the Claimant still exhibited signs of congestive heart failure at the time of Dr. Westerfield's examination, it should have been reflected in Dr. Westerfield's initial report.

[16] I took into consideration the fact that Dr. Vaezy may have presumed more years of coal dust exposure than actually are present in the Claimant's case. (See DX 14 at 9, "22 years"). Though I have found that the Claimant is unable to establish that he has clinical pneumoconiosis, the fact that Dr. Vaezy would conclude, after several months of treatment and a bronchoscope, that the Claimant "seems to have" coal workers' pneumoconiosis, is worthy of note.

other than coal dust exposure, for the Claimant's respiratory impairment. When making these assessments, Dr. Baker presumed coal dust exposure of 17 years, which is consistent with my findings.

Based on the foregoing, the evidence is clear that the Claimant has chronic lung conditions, most notably chronic bronchitis, which manifested themselves prior to his hospitalizations in 2003. No causative element other than coal mine employment has been established for his respiratory impairment. Though it is undeniably true that the Claimant's health deteriorated markedly in 2003, and has remained poor, the evidence indicates that his pre-existing respiratory impairment played a role in the Claimant's decline and his inability to return to full health. Any opinion as to any trigger other than coal dust is completely speculative, and is not supported by evidence of record.[17] I find, therefore, that the Claimant has established that he has pneumoconiosis, under the definition set out in § 718.201(a)(2), by a preponderance of evidence.

b. Whether the Pneumoconiosis "Arose out of" Coal Mine Employment

Under the governing regulation, a miner who was employed for at least ten years in coal mine employment is entitled to a rebuttable presumption that pneumoconiosis arose out of coal mine employment. § 718.203(b). The parties have stipulated that Claimant has established a coal mine employment history of 17 years. This rebuttable presumption is applicable only to cases involving clinical pneumoconiosis, and not legal pneumoconiosis. Where an individual's respiratory impairments consist of diseases other than clinical pneumoconiosis, the presumption may not apply. Andersen v. Director, OWCP, 455 F.3d. 1102 (11th Cir. 2006). In such cases, it remains the Claimant's burden to establish a causal link between his respiratory condition and his coal mine employment. § 718.201(b). See Cornett v. Benham Coal, Inc., 227 F.3d 569 (6th Cir. 2000).

The Claimant has no history of smoking, so smoking cannot be pointed to as a possible cause. As discussed in the previous paragraphs, I find the Employer's various hypotheses that the Claimant's pulmonary condition is due entirely to congestive heart failure, or to acute respiratory infections, or to occupational exposure to environmental irritants while working as a vehicle mechanic, to be either speculative, or contradicted by other credible evidence of record. It may be that one or more of these factors have played a role in the Claimant's current condition, especially since 2003. However, the weight of the evidence is that the Claimant's 17 years of dust exposure also played a role. Although I am unable to quantify the precise contribution of the Claimant's dust exposure in coal mine employment in his pulmonary impairment, I am satisfied that this exposure played more than a minimal role. Consequently, I find that the Claimant has established that his chronic lung conditions, which constitute pneumoconiosis within the meaning of the applicable regulation, arose out of coal mine employment.

[17] Dr. Westerfield's conclusion that the Claimant's condition is the result of repeated acute infections fails to answer the questions of what triggered the infections, and why the Claimant was unable to recover from them without damage.

c. Whether the Claimant is Totally Disabled

The Claimant bears the burden to establish that he is totally disabled due to a respiratory or pulmonary condition. Section 718.204(b)(1) states that a miner shall be considered totally disabled "if the miner has a pulmonary or respiratory impairment which, standing alone, prevents or prevented the miner: (i) From performing his or her usual coal mine work; and (ii) from engaging in gainful employment … requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over a substantial period of time." Nonpulmonary and nonrespiratory conditions which cause an "independent disability unrelated to the miner's pulmonary or respiratory disability" shall not be considered in determining whether a miner is totally disabled due to pneumoconiosis. See also Beatty v. Danro Corp., 16 B.L.R. 1-1 (1991). However, a nonpulmonary or nonrespiratory disease that causes a chronic respiratory or pulmonary impairment shall be considered in determining whether an individual is totally disabled due to pneumoconiosis. § 718.204(a). See generally Adams v. Director, OWCP, 886 F.2d 818 (6th Cir. 1989).

The regulation provides that, in the absence of contrary probative evidence, the following may be used to establish a miner's total disability: pulmonary function tests with values below a specified threshold; arterial blood gas tests with results below a specified threshold; or a finding of pneumoconiosis with evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(i)(ii) and (iii). Where the above do not demonstrate total disability, or appropriate medical tests are contraindicated, total disability may nevertheless be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine employment. § 718.204(b)(2)(iv).

Pulmonary Function Tests

The record contains the results of pulmonary function tests as follows (where there are two sets of numbers the second set reflects measurement after bronchodilation):

Date of Test	Physician	FEV_1	FVC	MVV	FEV_1/FVC Ratio	Valid ?
06/20/2003	Vaezy	1.79	2.12	unk	84%	No *
10/17/2003	Vaezy	1.45	1.97	unk	74%	No *
11/14/2003	Vaezy	1.27	1.66	unk	77%	No *
01/09/2004	Baker	1.43	2.15	unk	67%	Yes
04/19/2004	Baker	1.61	2.58	unk	62%	No **
06/14/2004	Broudy	1.50/1.63	2.07/2.29	65/65	72%/71%	Yes
07/21/2004	Westerfield	1.28/1.28	1.99/2.02	43/54	64%/63%	Yes

* These tests were submitted as part of medical treatment records and consist of a single trial, rather than the multiple trials required under Part 718.
** Incomplete flow volume loops. The record is silent as to why pulmonary function tests were performed in both January and April 2004 as part of the Claimant's OWCP evaluation.

In order to demonstrate total respiratory disability on the basis of the pulmonary function tests, the studies must, after accounting for gender, age, and height, produce a qualifying value for the forced expiratory volume [FEV_1] test and at least one of the following: a qualifying value for the forced vital capacity [FVC] test; a qualifying value for the maximum voluntary volume [MVV] test; or a value of the FEV_1 divided by the FVC that is less than or equal to 55%. § 718.(b)(2)(i). "Qualifying values" for the FEV_1, FVC, and the MVV tests are results measured at less than or equal to the values listed in the appropriate tables of Appendix B to Part 718.

The Claimant was born in April 1948 so he was either 55 or 56 years old at the time of the testing. His height was variously listed between 65 and 67 inches at different times and for different tests. Presuming a height of 66 inches, the average of these heights, the qualifying FEV_1 value for age 55 is 1.80 and for age 56 it is 1.78. The qualifying value for the FVC is 2.28 at age 55 and 2.26 at age 66. The qualifying value for the MVV is 72 at age 55 and 71 at age 56.

Based on the foregoing, it is clear that the Claimant has established total disability by means of the pulmonary function test. All of the valid tests show qualifying values, even after bronchodilation.[18] Similarly, all of the other tests, except for the April 2004 test that Dr. Baker administered, also show qualifying values.[19] In making this assessment, I considered the fact that Dr. Vaezy's tests were not considered valid, because they did not consist of multiple trials, as § 718103(b) requires. However, Dr. Vaezy's tests were submitted as medical treatment records, and not as evaluation tests. See § 725.414(a)(4). I note also that these test results are consistent with the other pulmonary function tests obtained for this Claimant.

Arterial Blood Gas Tests

A Claimant may also establish total disability based upon arterial blood gas tests. In order to establish total disability, the test must produce a qualifying value, as set out in Appendix C to Part 718. § 718.204(b)(2)(ii). Appendix C lists values for percentage of carbon dioxide [PCO_2] and percentage of oxygen [PO_2], based upon several gradations of altitudes above sea level. At a specified gradation (e.g., 2999 feet above sea level or below), and PCO_2 level, a qualifying value must be less than or equivalent to the PO_2 listed in the table.

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[18] I considered the fact that the Claimant's tests reflected that he was totally disabled even after bronchodilation as an indication that his condition is not amenable to such treatment, and so is permanent. Consolidation Coal v. Swiger, 98 Fed.Appx. 227 (4th Cir. 2004)(unpub). The fact that there was a minimal response to bronchodilation also tends to indicate that the Claimant does not have an asthmatic condition. I note that Dr. Baker speculated that the specific cause he could think of, other than coal dust exposure, for the Claimant's condition was an "asthmatic condition" (DX 38 at 3). Because these results tend to negate asthma as a cause for the Claimant's pulmonary impairment, Dr. Baker's conclusion that coal dust exposure must be a factor is strengthened. See Roberts & Schaefer Co. v. Director, OWCP, 400 F.3d 992 (7th Cir. 2005)(bronchodilators and asthma).

[19] Dr. Baker's April 2004 lacked an MVV value; had the MVV value been recorded, and had it been consistent with the other MVV values recorded on other tests, that test would likely also have qualified as evidence of total disability

The record reflects the following arterial blood gas tests:

Date of Test	Physician	PCO_2	PO_2
05/24/2003	Timmi-Ready +	44	69
05/25/2003	Timmi-Ready +	47	46
06/13/2003	Vaezy *	42	54
06/18/2003	Vaezy *	41	56
06/26/2003	Vaezy *	36	56
09/19/2003	Vaezy *	54	81**
10/03/2003	Vaezy *	46	70**
10/17/2003	Vaezy *	45	52
11/14/2003	Vaezy *	41	53
12/09/2003	Vaezy *	47	53
01/09/2004	Baker	44	53
06/14/2004	Broudy	40.5	66.5
07/21/2004	Westerfield	45	50

\+ Dr. Timmi-Ready's test results were included in hospitalization records (EX 7).
* Dr. Veazy's tests results were included in medical treatment records (DX 14).
** These tests were performed while the Claimant was on supplemental oxygen.

The arterial blood gas tests also establish that the Claimant is totally disabled. After June 2003, all of his arterial blood gas tests on room air, except for the one Dr. Broudy administered, reflect qualifying values. For PCO_2 values between 41 and 49, a qualifying PO_2 value at 2999 feet of altitude or lower is 60 or less: the Claimant's consistent PCO_2 value was between 41 and 47; his PO2 value was generally 56 or less, except for the Dr. Broudy test, in which he scored a non-qualifying value of 66.5. In coming to this conclusion, I took into consideration the fact that several tests reflect that the Claimant was on supplemental oxygen. (The use of oxygen affects the subject's percentage of oxygen (PO_2) value). Dr. Veazy's tests, however, were administered in connection with medical treatment, and the records of the conditions under which these tests were administered are incomplete. From October 2003 forward, however, Dr. Veazy's test results reflect qualifying values, and these results are consistent with arterial blood gas tests that other physicians administered in later months.[20]

Cor Pulmonale

A miner may demonstrate total disability with, in addition to pneumoconiosis, medical evidence of cor pulmonale with right-sided congestive heart failure. § 718.204(b)(2)(iii). The

[20] I also considered the anomalous result from Dr. Broudy's test. The regulation requires that an exercise test be given (unless medically contraindicated) if a resting test does not produce a qualifying result. § 718.105(b). The record does not reflect the conditions under which the test was given, or why an exercise test was not administered. I note that Dr. Broudy also gave a pulmonary function test to the Claimant on the same date, and this test produced a result demonstrating total disability.

record contains discussion of episodes of congestive heart failure, but does not include any diagnosis of cor pulmonale with right sided congestive heart failure. Accordingly, I find that the Claimant has not established total disability under this provision.

Physician Opinion

The final method of determining whether the Claimant is totally disabled is through the reasoned medical judgment of a physician that the Claimant's respiratory or pulmonary condition prevents him from engaging in his usual coal mine work or comparable gainful employment. Such an opinion must be based on medically acceptable clinical and laboratory diagnostic techniques. § 718.204(b)(2)(iv). A reasoned opinion is one that contains underlying documentation adequate to support the physician's conclusions. Field v. Island Creek Coal Co., 10 BLR 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. Id.

For this Claimant, the medical opinions parallel the results of the pulmonary function and arterial blood gas testing by concluding that the Claimant is disabled from coal mine employment, due to his pulmonary conditions. Dr. Broudy, for example, states that "it is likely" that the Claimant does not retain the respiratory capacity to perform coal mine employment (DX 29 at 8). Dr. Westerfield states that the Claimant is "totally disabled" due to respiratory disease (DX 35 at 3). In response to a direct inquiry from the District Director, Dr. Baker opines that the Claimant does not have the respiratory capacity for coal mine employment, and cites the Claimant's reduced FEV_1 level and his chronic bronchitis (DX 38 at 3).

The physician opinions stating that the Claimant is disabled from coal mine employment are consistent with the evidence of total pulmonary disability from the Claimant's pulmonary function and arterial blood gas tests. Based on all of these, therefore, I find that the Claimant has established, by a preponderance of evidence, that he is totally disabled due to his pulmonary impairments.

d. Whether the Claimant's Disability is due to Pneumoconiosis

Lastly, the Claimant must establish that he is totally disabled due to pneumoconiosis. This element is fulfilled if pneumoconiosis, as defined in § 718.201, is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment. § 718.204(c). The regulations provide that pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition, or materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. A Claimant can establish this element through a physician's documented and reasoned medical report. §718.204(c). Cornett v. Benham Coal, Inc., 277 F.3d 569 (6th Cir. 2000).

In order to prevail in his claim for benefits, the Claimant is not required to demonstrate that pneumoconiosis was the only cause of his respiratory impairment, or even that it was the primary cause. The role that coal dust exposure plays in a Claimant's condition, however, must be more than minimal. The Claimant must establish that pneumoconiosis is a "contributing

cause of some discernable consequence" to his impairment. Peabody Coal Co. v. Smith, 127 F.3d 504, 507 (6th Cir. 1997). A nonpulmonary disease which causes an independent disability unrelated to the Claimant's pulmonary disability shall not be considered in determining whether an individual is totally disabled due to pneumoconiosis. However, if a nonpulmonary or nonrespiratory condition or disease causes a chronic respiratory or pulmonary impairment, that condition or disease shall be considered in determining whether the miner is or was totally disabled due to pneumoconiosis. § 718.204(a).

As set forth in Dr. Baker's report, the evidence shows that the Claimant had chronic bronchitis and showed symptoms of disabling pulmonary impairment, well before his first episode of congestive heart failure. As Dr. Vaezy's treatment records show, the Claimant also has had episodes of acute bronchitis, on top of his chronic respiratory ailments. The record presents a picture of an individual whose health took a precipitous decline in 2003. The same record also presents evidence that the Claimant had significant, though perhaps not disabling, respiratory impairment prior to that year. The evidence establishes that the Claimant currently is totally disabled, even when not acutely ill. I find that the Claimant's underlying respiratory impairment has played a major role in the Claimant's total disability.

Taken as a whole, I find that the evidence establishes that the Claimant's pneumoconiosis is a substantially contributing cause of the Claimant's totally disabling respiratory impairment. While I am unable to articulate the precise amount that the Claimant's pneumoconiosis contributed to his disability, I find that this condition played a significant role. I find, therefore, that the plaintiff has met his burden, by a preponderance of evidence, that his total disability is due to pneumoconiosis. See Peabody Coal Co. v. Smith, 127 F.3d 504 (6th Cir. 1997); Cornett v. Benham Coal, Inc., 227 F.3d 569 (6th Cir. 2000).

e. Date of onset of disability.

Benefits for a miner who is totally disabled due to pneumoconiosis commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. § 725.503(b). Medical evidence of total disability does not establish the date of entitlement: rather, it shows that a claimant became disabled at some earlier date. Owens v. Jewell Smokeless Coal Corp., 14 B.L.R. 1-47, 1-s50 (1990).

The Claimant filed his Claim in December 2003. When Dr. Baker examined him in January 2004, he was already totally disabled, as defined in the regulation. § 718.204(b)(2). The record contains medical treatment records that indicate that the Claimant was totally disabled as early as May 2003. However, as noted above, the Claimant was hospitalized for acute conditions in May, June, and September 2003, so his respiratory condition may have been affected by these crises. After the Claimant's third hospitalization, however, Dr. Vaezy's test results indicate that the Claimant was totally disabled. In particular, the arterial blood gas tests that Dr. Vaezy supervised in October, November, and December 2003 reflect that the Claimant was totally disabled during those months.

Based on the foregoing, I find that the Claimant's total disability began in October 2003. Consequently, I find that the Claimant is entitled to benefits commencing in October 2003. See § 725.503(b).

IV. CONCLUSION

Based upon applicable law and my review of all of the evidence, I find that the Claimant has established his entitlement to benefits under the Act.

V. ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which a Claimant is represented by counsel and is found to be entitled to benefits under the Act. No award of attorney's fees for services provided to the Claimant is made herein because no fee application has been received.

Within 30 days, Claimant's counsel shall submit a fee application, in conformance with §§ 725.365 and 725.366. The application must be served on all parties, and a service sheet documenting such service must accompany the application. Parties have ten (10) days following the receipt of any application within which to file any objection. The Act prohibits the charging of a fee in the absence of an approved application.

VI. ORDER

The Claimant's Claim for benefits under the Act is AWARDED.

A

ADELE H. ODEGARD
Administrative Law Judge

Cherry Hill, New Jersey

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).